Section of Laryngology 27

Osteoma of Frontal Sinus.

By D. F. A. NEILSON, F.R.C.S.

MALE, aged 43. First seen 1925. He then consulted his doctor on account of pain and inflammatory swelling over the left eye. This lasted for two weeks, subsided, and has not recurred. For some years previously he had noticed a swelling in the middle of his forehead.

No history of headaches or of frontal pain except during the attack mentioned Nasal fossæ appear normal.

Since 1925 his sight, which, before that date, was perfect, has deteriorated rapidly. The fundi have been examined several times and reported as normal, the defective vision being due to marked astigmatism and myopia. Stereoscopic X-ray films [shown] demonstrate an osteoma with well-defined margin and surrounded in places by the expanded walls of the frontal sinus. The cranial fossa is invaded to quite an appreciable extent, and in this locality the roof of the sinus is well away from the margin of the osteoma. Presumably a mucocele is developing.

The patient has refused treatment, but the rate of increase in size of the growth is being observed.

During the first year no increase was detected.

Sir JAMES DUNDAS-GRANT asked how the defect of vision and the development of polypi in the right nasal cavity could be explained in this case. It seemed as if there had been some invasion of the posterior ethmoidal cells, involving the oculo-motor nerves.

Two Specimens of Exostosis arising in the Floor of the Frontal Sinus.

Shown by WALTER HOWARTH, F.R.C.S.

BOTH these tumours produced a mucocele of the frontal sinus. They are shown as a corollary to the foregoing case.

Tumour of the Nose.

By G. W. DAWSON, F.R.C.S.I.

MALE, aged 24.

There is a tumour on the right side of the nose, extending from the eyebrow to the ala of nose. It is soft and ill-defined and has been present for sixteen years.

Discussion.—Sir JAMES DUNDAS-GRANT said he thought the growth was a lymphatic nævus.

Dr. W. HILL said he would treat it with the ionization needle.

Mr. A. J. M. WRIGHT said electrolysis might be worth trying here.

Mr. M. VLASTO said that as the condition was obviously benign and as, apart from the disfigurement, the swelling did not incommode the patient, he would not advise operation. As an alternative diagnosis, he suggested that of a soft lipoma.

Miss ELEANOR LOWRY said that a few weeks ago she had had a patient with a soft swelling over the mastoid, which, it was said, varied in size. There was a chronic discharge from the ear, and, on operation, the swelling was found to be a lipoma. Possibly the present case might be of the same nature.

Dr. IRWIN MOORE said he, too, thought the swelling was a lipoma, and would advise leaving it alone.

Two Cases of Laryngectomy; Specimens Shown.

By W. J. HARRISON, M.B.

Case I.—MALE, age 54. Complained of weakness of the voice and huskiness of about three months' duration. On examination the right cord was found to be motionless and the posterior third had a "mouse-nibbled" appearance. The right arytænoid was

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immobile and there was a good deal of swelling in this region, extending into the interarytænoid space. Wassermann reaction weakly positive. Pathologist's report on specimen: "A typical squamous-celled carcinoma." The patient is edentulous. Operation, July 20, 1926: Laryngectomy without a preliminary tracheotomy. Larynx removed from below upwards. Uneventful recovery. Primary union of the wound. Highest temperature 99·6. Fastest pulse-rate 112. Greatest number of respirations per minute 24. Now speaks in a whisper, which is becoming louder and more distinct. Has put on weight since the operation (he says 16 to 17 lb.). Specimen opened from the front.

Case II.—Female, aged 37. Had noticed an alteration in her voice for six months, she had taken little notice of it. Had had attacks of weakness of her voice for the past two years.

On examination a fungating growth was found in the upper part of the larynx, on the right side, and a gland on that side of the neck was enlarged. Wassermann negative. Pathologist's report on specimen: "A squamous-celled carcinoma." Patient wears complete dentures. Operation January 4, 1927. Laryngectomy without preliminary tracheotomy. Epiglottis removed owing to situation of growth. The division of the muscles was made some distance from their insertion, as the gland over the cricothyroid membrane was enlarged. The gland in the neck and the gland-bearing tissue in this region were removed.

Considerable difficulty was experienced in closing the pharyngeal wound owing to the free removal of the larynx.

Some sutures in the skin have given way, but healthy granulations are springing up and the wound is closing rapidly (January 20, 1927).

General condition very satisfactory. Temperature once reached 100° F. (on the sixth day after operation). Highest pulse-rate 114, for a short time. Respirations 24 per minute for the first twenty-four hours, since then 22 per minute. Specimen opened from behind.

Discussion.—Mr. HARRISON said that the method he had adopted in dressing these cases was to wrap the tracheotomy tube with gauze so that it completely filled the lumen of the trachea. Ribbon gauze was packed from below upwards into the wound and a piece of gauze was packed in below this immediately above the trachea. These packs had to be changed frequently, at first at about twenty-minute intervals. He wished to learn what other methods Members used. He got such patients up in three days, sitting in an armchair. He would welcome suggestions as to how long the nasal feeding tube should be retained in use in cases which were doing well. He had seen it stated that these patients generally died within three years of the operation, from lung complications. What was the experience of others in regard to lung complications?

Sir STCLAIR THOMSON said that these interesting specimens were very instructive. In similar cases, in early days, he (the speaker) had attempted laryngo-fissure, and usually there had been a recurrence. The kind of case from which these specimens were shown was unsuitable for laryngo-fissure, but was usually admirably suitable for laryngectomy. In the case of the male, it was remarked that the cord was motionless, and his (the speaker's) statistics showed that recurrence, after laryngo-fissure, was much more frequent in cases in which the cord was fixed, than in those in which it was mobile. Mr. Harrison had told him that what was remaining of the cord in the second case had been quite concealed. Mr. Harrison had acted rightly in performing laryngectomy, instead of splitting the larynx or doing laryngo-fissure, but if Mr. Howarth had to operate further on his patient, he (Sir StClair) suggested that it would be worth trying to save part of the larynx, however small, even if a tracheotomy tube had to be worn for the remainder of life. He (himself) had had one case in which he had performed secondary laryngo-fissure. That was three years ago, and the patient was going about in society; the trachetomy tube in her neck was concealed, and her voice was certainly better than none at all.

With regard to these people continuing to breathe through the neck, there was no particular danger in that. In his (the speaker's) book there were references to people who, having

undergone tracheotomy at the age of 30, had died aged 80, and had worn the tube during the intervening time. Despite the *a priori* physiological arguments as to the importance of warming inspired air in the nasal passages, he knew of people who, while wearing their tracheotomy tube, played tennis, begat children, and did all the other things the ordinary citizen accomplished, except swim! Moreover, they did not seem more subject to bronchitis than were other people. The malignancy in Mr. Howarth's case was of a low form, and he (the speaker) thought that an operation might be performed, which, as regarded severity, would lie somewhere between laryngo-fissure and complete laryngectomy.

Mr. C. A. SCOTT RIDOUT said that he had shown at a previous meeting a patient with a similar condition. This patient had progressed well and was quite cheerful, having had no trouble at all, though since the operation he had suffered from an acute attack of appendicitis. He had never had a cold in the head since the throat operation.

Mr. LIONEL COLLEDGE said that in the first of these specimens the epiglottis had been left; in the second it had been removed with the larynx. On close examination the growth was seen to approach closely the cut edge of the epiglottis. It was better, when removing the whole larynx, to take away the epiglottis at the same time. In some of his own cases, on examining the patient with the mirror, the epiglottis had appeared to be free, but afterwards, in the specimen, it was seen to be deeply infiltrated. With regard to drainage, he had not found gauze drains efficient. He used rubber tubes instead, and as soon as there was much discharge he syringed the tubes through with eusol; a simple rubber tube having lateral holes was the best form of drain.

Sir JAMES DUNDAS-GRANT said that in a case in which he had seen Mr. Lionel Colledge operate, the existing tracheotomy wound was adherent to the surface of the neck, and Mr. Colledge had cut through the trachea above it, bringing the skin together behind the cut surface of the trachea, so that he was then able to plug it until union was established and so to protect the lungs from infection—the patient breathing through the tracheotomy tube. Might not this safeguard be more frequently adopted?

Mr. LIONEL COLLEDGE (in reply to Sir James Dundas-Grant) said that a preliminary tracheotomy allowed the cut end of the trachea to be packed so that the trachea was completely shut off. But in three cases in which there had been preliminary tracheotomies there had been recurrence in the tracheotomy wound, and he wondered whether making an additional wound there before doing the main operation did not expose the patient to an additional risk of recurrence.

Dysphagia for Three Months due to Foreign Body in the Œsophagus.

By C. GILL-CAREY, F.R.C.S.Ed.

History.—Patient, a woman of 32, complained of inability to swallow solid food for three months. Could not remember having swallowed a foreign body. Had lost 2 stone in weight.

Examination.—No abnormality in larynx; no excess mucus in the pyriform fossa.

X-ray examination by Dr. Graham Hodgson, who reported an abnormal opacity in the œsophagus between the sixth and seventh cervical vertebræ.

Œsophagoscopy.—Piece of glass, a portion of which is shown, removed from the œsophagus 25 cm. from incisor teeth. No ulceration of the œsophagus was present.

Complete recovery after removal of the foreign body.

Dr. ANDREW WYLIE (President) said that he had seen the patient in this case, and she had complained very little. Mr. Gill-Carey had removed the foreign body in a very skilful manner. It was uncertain at the time of the operation whether a foreign body was present.

Lymphosarcoma of the Tonsil and Tongue with Glandular Involvement.

By NORMAN PATTERSON, F.R.C.S.

PATIENT, aged 64, female.

History.—Eight years ago the patient noticed swellings on the left side of the neck. Later on she was treated at the London Hospital by X-rays, and the enlargement of